Comments for the Record
United States House of Representatives
Committee on Ways and Means
Health Subcommittee
Hearing on Protecting Patients from Surprise Medical Bills
Tuesday, May 21, 2019, at 2:00 p.m.

By Michael G. Bindner
Center for Fiscal Equity

Chairman Doggett and Ranking Member Nunes, thank you for the opportunity to submit these comments for the record to the House Ways and Means Health Subcommittee. If it is May, it is time to discuss health care, as the dates on my attachments show.

Participants in Catastrophic Care with a Health Savings Account are never surprised by unexpected medical bills, since they signed up for it. If they do not realize that there will probably be a gap between the catastrophic deductible and the savings account, then it is on them. Adding a portable Medical Line of Credit would still create unexpected costs, but they would at least be funded at service – although this would limit the usefulness of the system in ending care when it is not needed. Most people will put access ahead of long-term savings. It is why the poor under-invest in tax favored savings accounts.

Beneficiaries of comprehensive health care are surprised when they see bills that will eventually be covered by their carrier, as well as those which are not covered that they must still pay.

The deepest cut comes for those of the working poor who have signed up for care under the Affordable Care Act in the lower cost plan. I am among those. A broken rib when I was covered by the ACA resulted in $900 in medical bills I was not expecting (and in truth, I should have simply waited for my Medicare to kick on, but honesty or stupidity had me sign up for the ACA when I could no longer meet the asset test).

My experience is duplicated for many others. The reality for most is that these bills are never paid, so the providers eat the cost anyway. Making patients "responsible" has not helped providers one bit. They still eat much of the cost of treating "covered" patients.

Patients under Medicaid have no surprise medical bills. Neither will anyone if Medicare for All is adopted. Indeed, Medicare for All is really Medicaid at the beneficiary level with payments for providers at the Medicare level (else, the Uniformed Public Health Service would have to employ all medical personnel.

Attachment One duplicates our testimony from last year and previously on consumer driven health plans, including the aforementioned Medical Line of Credit and who it works with other elements of the plan, how a Net Business Receipts/Subtraction VAT can be used to fund additional funding to increase coverage, fund a Public Option or it's big brother, Medicare for All. A brief discussion of Medicare for All is provided in Attachment Two.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment One: Consumer-Directed Health Plans, June 6, 2018 and similar testimony from May 17, 2016.

Proposals along the lines mentioned here have long been a part of our standard package of health care reforms. We have long advocated a conversion to catastrophic insurance with a medical savings account to pay for appointments and drugs, although we have always suggested a third element – a Medical Line of Credit to bridge the gap between the current MSA balance at the catastrophic deductible. The MLC would also pay for services, including acupuncture and reproductive health that may not be covered or coverable under catastrophic insurance.

Under our standard tax reform proposal, catastrophic policies would be purchased by all employers (and certain self-employed) as an offset to the Net Business Receipts Tax/Subtraction VAT. The Net Business Receipts Tax (NBRT) includes tax expenditures for family support, health care and the private delivery of governmental services. It will fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

While this raises the tax rate, the lack of any tax subsidy would doom private insurance and deny most families medical care. Likewise, the Health Savings Account would be provided by employers, but would be a deduction rather than a credit. Medical Lines of Credit would be funded entirely by employees with no tax advantage – as under our plan most employees would not pay any income taxes.

Personal experience with cardiac care (luckily a succession of false alarms) showed that, while this approach makes economic sense, it does not jibe with how doctors operate. There is no price schedule in the waiting or exam rooms to compare costs for proposed procedures or tests. Health care is not a normal good. While it responds to market pressures, some care cannot be limited by them. I also came to the conclusion with the passage of health care reform – and the electoral rejection of the health care reform above which was not far from what Senator McCain proposed in his 2008 run (and which was not even mentioned as the Republican alternative in the Obamacare debate) – that Americans like their comprehensive insurance. Most importantly, while the Medical Line

of Credit is essential for complete health care, its inclusion essentially short circuits any decision to shop for care.

If the McCain approach cannot pass, will the Affordable Care Act survive the test of time (it has certainly survived all attempts to repeal it)? Possibly. The key concept, that people in marginal jobs deserve the same tax subsidies that corporate employees get is sound. Those parts that fulfill that need, which originated in the Heritage Foundation (which even now clamors for repeal) are also worthy.

What is less defensible are the higher non-wage income taxes used to fund it, although no bill which just repeals these will survive a Budget Act point of order in the Senate (regardless of House Rules) nor would the political optics look good. Repeal would hurt too many Americans, so expansion of the tax (along with a rate cut) with some form of consumption or payroll tax– such as the one proposed by Senator Sanders in his single payer plan (or by Mrs. Clinton during her husband's health care reform effort). In our proposal, the consumption tax used would be the NBRT/Subtraction VAT.

The main danger to the Affordable Care Act is ease of entry and exit. If it is too easy to get in, then people will wait until they are sick to sign up. After they are well, any plan will stop coverage if you stop sending in your monthly premium check. If enough people do that, rates go up and the cycle goes down. This eventually leads to a collapse in the system that can be fixed in one of two ways – give everyone cheap and mandatory health care or place health insurers into bankruptcy, like General Motors and Chrysler, and reorganize them into a single-payer system (without any congressional action). Had the leadership laid out this scenario, it might have stopped the Affordable Care Act – and insurance companies would have most assuredly stopped contributions to the GOP.

The low-cost system with catastrophic care would operate as above (and would hopefully include the Medical Lines of Credit). Single-payer care would be funded by the NBRT/Subtraction VAT. Such a tax is superior to the payroll tax proposed by Senator Sanders because it would hit profit. The upper-income payroll taxes for non-wage income would repealed and incorporated into the NBRT.

Under Single-Payer, we propose an additional option. Firms that provide direct health care, such as automobile manufacturers, would not pay for third party coverage at all. The cost of the coverage provided would be an offset to the NBRT.

We believe that our current insurance system adds no value to health care. Theoretically, insurance pools everyone's costs and divides them up with everyone paying a monthly share, regardless of the risk they pose. The profit motive has given us differential premiums based on risk and age. Indeed, the age based premiums in the last attempted health reform were so unaffordable to older Americans in individual plans that the bill could not pass the Senate. Single payer plans, funded through the NBRT, would not have this feature and insurance companies doing claim processing for the government would be paid an adequate profit with little risk.

Short of that, an NBRT subsidized Public Option would allow sicker, poorer and older people to enroll for lower rates, allowing some measure of exclusion to private insurers and therefore lower costs. Of course, the profit motive will ultimately make the exclusion pool grow until private insurance would no longer be justified, leading-again to Single Payer if the race to cut customers leads to no one left in private insurance who is actually sick.

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise.

Attachment Two: - Examining MACRA Implementation and the Road Ahead (Finance), May 8, 2019/Medicare Advantage Program, May 8, 2018

Medicare for All, Do We Already Have It?

Medicare for All is a really good slogan, at least to mobilize the base. One would think it would attract the support of even the Tea Partiers who held up signs saying "Don't let the government touch my Medicare!" Alas, it has not. This has been a conversation on the left and it has not gotten beyond shouting slogans either. We need to decide what we want and whether it really is Medicare for All. If we want to go to any doctor we wish, pay nothing and have no premiums, then that is not Medicare.

There are essentially two Medicares, a high option and a low one. One option has Part A at no cost (funded by the Hospital Insurance Payroll Tax and part of Obamacare's high unearned income tax as well as the general fund), Medicare Part B, with a 20% copay and a $135 per month premium and Medicare Part D, which has both premiums and copays and is run through private providers. Parts A and B also are contracted out to insurance companies for case management. The other option is the Medicare Advantage (Part C) HMO. You pay a premium and copays, but there is much more certainty, while ABD are more like a PPO, but costs can go much higher. So much higher that some seniors and the disabled get Medicap coverage for the copays. Which is high and which low, I am not sure. They are both now managed care.

Medicaid lingers in the background and the foreground. It covers the disabled in their first two years (and probably while they are seeking disability and unable to work). It covers non-workers and the working poor (who are too poor for Obamacare) and it covers seniors and the disabled who are confined to a long-term care facility and who have run out their assets. It also has the long-term portion which should be federalized, but for the poor, it takes the form of an HMO, but with no premiums and zero copays.

Obamacare has premiums with income-based supports (one of those facts the Republicans hate) and copays. It may have a high option, like the Federal Employee Health Benefits Program (which also covers Congress) on which it is modeled, a standard option that puts you into an HMO. The HMO drug copays for Obamacare are higher than for Medicare Part C, but the office visit prices are exactly the same.

What does it mean, then, to want Medicare for All? If it means we want everyone who can afford it to get Medicare Advantage Coverage, we already have that. It is Obamacare. The reality is that Senator Sanders wants to reduce Medicare copays and premiums to Medicaid levels and then slowly reduce eligibility levels until everyone is covered. Of course, this will still likely give us HMO coverage for everyone except the very rich, unless he adds a high-option PPO or reimbursable plan. Either Medicare for All or a real single payer would require a very large payroll tax (and would eliminate the HI tax) or an employer paid subtraction value added tax (so it would not appear on receipts nor would it be zero rated at the border, since there would be no evading it), which we discuss below, because the Health Care Reform debate is ultimately a tax reform debate. Too much money is at stake for it to be otherwise, although we may do just as well to call Obamacare Medicare for All and agree to leave it alone.

Contact Sheet

Michael Bindner
Center for Fiscal Equity
14448 Parkvale Road, Suite 6
Rockville, MD 20853
301-871-1395 landline
240-810-9268 cell
No fax
fiscalequitycenter@yahoo.com

Health Subcommittee

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